

120 Royall Street · Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

Employer/Policyholder				T	Dept. ID
Employee Name (Last, First, Middle)			L	Socia)	al Security Number
Home Address (Street, City, State, Zip)				Telephone	#
Gender (M/F) Occupation or Job Title Date of Birth	Age PAYROL	L Weekly Monthly	☐ Bi-Weel	,	s: \$
Average Hours Worked Date of Hire or Date of Full Time Employment	if different Effective Da	te	s	tate	Class
Spouse (Last, First, Middle)	Gender (M/	Date of Bi	rth	A	ge No. of Deper
You Must Have Basic Coverage to Elect Voluntary Coverage	You Must Have Vo	oluntary Cove	erage to E	lect De	pendent Cover
BASIC:	VOLUNTARY:				
Group # Div YES NO Insurance Amount	Group #	Div	- YES	NO	Insurance Amou
LIFE & AD&D	LIFE & AD&D			□ \$	
	SPOUSE			□ \$	
	DEPENDENT LIF	E:			
	CHILD(REN)		۵	□ \$	
Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Perc	centage of Benefit must equ	al 100%) List A	dditional	Beneficia	ries on separate s
	e of Birth Social Sec		Tel. #		ationship % of B
Contingent Beneficiary(ies):					
			1.0		
If you designate more than one beneficiary, please be sure the total p payable for each beneficiary, the total proceeds payable will be divided equaproceeds to you.	ercentages of benefit ally among each benef	ciary. If an in	sured dep	lo not de endent	esignate a percei dies, we will pa
payable for each beneficiary, the total proceeds payable will be divided equa	ally among each benef	ciary. If an ir	sured dep	do not de endent	esignate a percei dies, we will pa
payable for each beneficiary, the total proceeds payable will be divided equa proceeds to you.	CE - Employee Signal me eligible) under the puthorize deductions, in disabled on the date is understand that if I devown expense, evidence	ture Required revisions of the fany, from many insurance use the control of the c	e Group Porty earning	olicy or ogs of the for whictory to	Group Policies is e required pren come effective, I ch I am now eli Boston Mutual
I apply for the insurance for which I am now eligible (or for which I may become to my employer by the Boston Mutual Life Insurance Company and au contribution toward the cost of the insurance. I understand that if I am only become insured on the date I return to active full-time work. I further to and I desire to participate in the plan at a later date, I must furnish, at my Insurance Company. Signature of Employee	ally among each benefice a complete signal me eligible) under the parthorize deductions, in disabled on the date of anderstand that if I degrown expense, evidence	ture Required revisions of the fany, from many insurance use the control of the c	Group Pony earning	olicy or ogs of the for whictory to	Group Policies is e required pren come effective, I ch I am now eli Boston Mutual
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